

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

318
FILED MAY 27 1963

Primary Registration District No.

1003

Registrar's No.

5115

STATE FILE NUMBER

=63-021622

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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USE BLACK INK
OR
TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Washington	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 22 1/2 hrs	c. CITY OR TOWN Mineral Point Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Childrens		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Route 1 Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Martty Middle Lynn Last Goodson		4. DATE OF DEATH Month May Day 11 Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-9-63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11a. FATHER'S NAME William Lewis		11b. MOTHER'S MAIDEN NAME Rita Kean	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT St. Louis 10, Mo.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningitis DUE TO (b) Pneumonia DUE TO (c) Sepsis 768.0	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 5-10-63 to 5-11-63 and last saw him alive on 5-11-63 Death occurred at 2:28 P m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Deed or title) Francis M. Henderson M.D. 22b. ADDRESS 500. South Kingshighway 22c. DATE SIGNED 5/12/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 5-13-63	23c. NAME OF CEMETERY OR CREMATORY NEW Diggings	23d. LOCATION (City, town, county) Rt. 1 Mineral Pt. Mo.
24. FUNERAL DIRECTOR SPARKS	25. DATE RECD. BY LOCAL REG. MAY 13 1963	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____ Student-Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Ronald Sparks

Licensed Embalmer No.

4819

P. O. Address

Fotosi, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.